To: Board of Directors

Date of Meeting: 26th July 2017 Agenda Item: 6

| Title |
|---|
| **Quality Report Month 3** |
| Responsible Executive Director |
| Dr George Findlay, Chief Medical Officer<br>Nicola Ranger, Chief Nurse |
| Prepared by |
| Mark Renshaw, Deputy Chief of Safety |
| Status |
| Public |
| Summary of Proposal |
| The report describes performance against safety and quality key performance indicators in Month 3, in the domains of safety, effectiveness and patient experience |
| Implications for Quality of Care |
| The report includes exceptions in respect of challenges currently being faced in meeting national timescales for completing serious incidents investigations, the increase in HSMR and SHMI, a higer rate of pressure damage, mixed sex accommodation breaches and the timeliness of complaints responses |
| Link to Strategic Objectives/Board Assurance Framework |
| This report incorporates key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and highlighting issues of concern. **A safety and quality scorecard is appended** |
| Financial Implications |
| Future reports will include KPIs that have potential financial impact (e.g. CQUIN) |
| Human Resource Implications |
| Safer staffing levels are incorporated in the safety and quality scorecard |
| **Recommendation** |
| **The Board is asked to NOTE the report** |
| Communication and Consultation |
| Not applicable |
| Appendices |
| None |

## 1 INTRODUCTION

1.1 This report brings together key national, regional and local indicators relating to quality and safety. The purpose of the report is to bring to the attention of the Trust Board quality performance within Brighton and Sussex University Hospitals NHS Trust (BSUH).

1.2 The paper describes performance on an exceptional basis determined by RAG (red/amber/green) ratings based on national, regional or local targets.

## 2 KEY QUALITY OBJECTIVES

2.1 Dashboard Definitions

2.1.1 A Safety and Quality Scorecard is appended to the Board report. Key indicators are detailed in table 1. Figures are in-month figures (e.g. the number of falls reported in June) unless otherwise stated.

2.1.2 Exception reports are included under the relevant section of this report (i.e. under the broad headings Effectiveness, Safety and Experience).

2.1.3 Only the current financial year and year to date values are RAG rated, with the exception of those metrics reported in arrears with no data in the current financial year where the most recent data-point of last year is RAG rated.

2.2 Overview of Key Quality Objectives

2.2.1 The following table shows performance against key, top level quality indicators.

**Table 1: key performance indicators**

| Indicator | April 2017 | May 2017 | June 2017 |
|---|---|---|---|
| Trust crude mortality rate (non-elective) | 2.89% | 3.03% | 2.72% |
| Hospital Standardised Mortality Ratio | | | |
| Safety Thermometer (Harm-Free Care) | 95.2 | 95.7 | 97.1 |
| Number of Serious Incidents Requiring Investigation | 4 | 4 | 2 |
| Never Events | 0 | 0 | 1 |
| Grade 3 and 4 Pressure Ulcers | 0 | 0 | 0 |
| Falls resulting severe harm or death | 1 | 1 | 1 |
| Numbers of hospital attributable MRSA | 0 | 1 | 0 |
| Numbers of hospital C. diff cases | 1 | 3 | 3 |
| The Friends and Family Test: Percentage Recommending Inpatients | 96.7% | 96.9% | 95.4% |
| The Friends and Family Test: Percentage Recommending A&E | 88.7% | 89.4% | 87.6% |
| Mixed Sex Accommodation breaches (number of breaches) | 76 | 48 | 39 |
| Number of complaints | 77 | 94 | 91 |

## 3 EFFECTIVENESS

3.1 Crude Trust Mortality

3.1.1 Crude non-elective mortality for the period April to June was 2.88% this is on the average for the previous 12 months of 3.46%, it is also lower than the comparable period last year when the rate was 3.17%

3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 There is a delay in data being available in Dr. Foster tools to allow for coding and processing by the Health and Social Care Information Centre and Dr. Foster. The most recent data available is February 2017.

3.2.2 The Trust's HSMR for the twelve months to March 2017 is 97.81 (where 100 is the level predicted by the Dr. Foster model). Since May 2016 the Trusts HSMR has been steadily increasing from a low of 88.38.

3.2.3 The Trust Mortality Review Group (TMRG) is overseeing the implementation of the new national requirements regarding Learning from Deaths.

3.3 Summary Hospital-Level Mortality Indicator (SHMI)

3.3.1 The latest data available on HEDs which covers the period March 2016 to February 2017 reports a SHMI of 99, i.e. mortality is 1% below the expected value. Like HSMR the SHMI has been steadily increasing from a low of 94.3 in May 2016.

## 4 SAFETY

4.1 Central Alert System (CAS) Safety Alerts

4.1.1 There were no outstanding CAS alerts for the Trust in the period up to April 2017, a significant reduction from the position from July 2016 onwards.

4.2 Serious Incidents Requiring Investigation (SIRIs)

4.2.1 There were 10 Serious Incidents declared during the period April to June. The outcome in three of these incidents are currently graded as catastrophic, a further three are classified as severe. Below is a list of all ten SI's:

- Never Event - Wrong site block
- Patient on RTT pathway for 83 weeks.
- Obstetric / surgical deterioration
- Concerns that in pregnancy the Symphysis Fundal Height was abnormal at 40+3 and that this was not escalated
- C-section resulting in a delay of 26 minutes to deliver baby who sustained fractures and brain injury
- Diabetic eye screening backlog
- Fall on Courtyard 8
- Acute cardiac event not noted
- AAA Screening Programme
- Death following intubation

4.3 Infection prevention and control

4.3.1 There was 1 cases of hospital-attributable Clostridium difficile during April.

4.3.2 On review of the patient records, root cause analysis (RCA) identified that there had been lapses in care in relation to sample taking and processing within the community and the acute Trust, as well as delayed source isolation of the patient. The RCA identified that the Standard Operational Procedure used within the Laboratory to process C. difficile testing for patients in the community, did not follow the national guidance of automatically testing for patients above the age of 65 years. These have all been addressed through review and rewriting of the Standard Operational Procedure by Laboratory staff training and further audits for the clinical area.

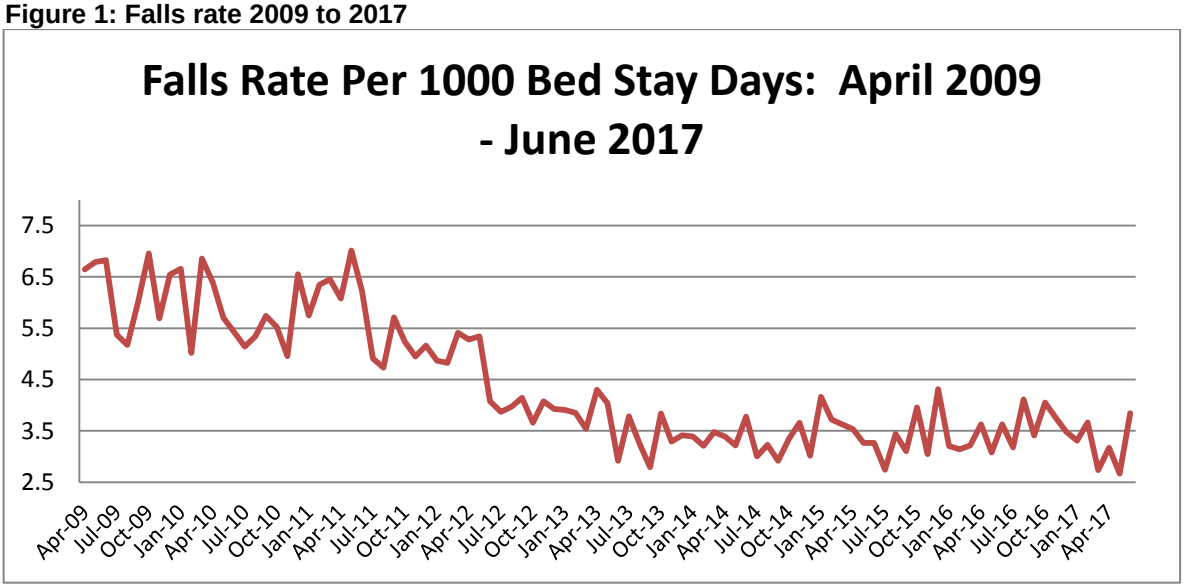
4.3.3 The allocated Trust target limit for 2017/18 is set at 46 for the year. This equates to a rate of infection of 3.69 per 100,000 bed days.

4.3.4 There was one hospital attributable MRSA cases in the May 2017.

4.4 Inpatient Falls

4.4.1 The falls rate for the first quarter of 2017-18 is 3.22 falls per 1000 bed stay days; this is an 8% reduction on the previous financial year. Monthly falls data has been collected since June 2008. In May 2017 the lowest monthly total of falls (n=57) and the lowest ever falls rate (2.66 per 1000 bed stay days) were reported.

**Figure 1: Falls rate 2009 to 2017**



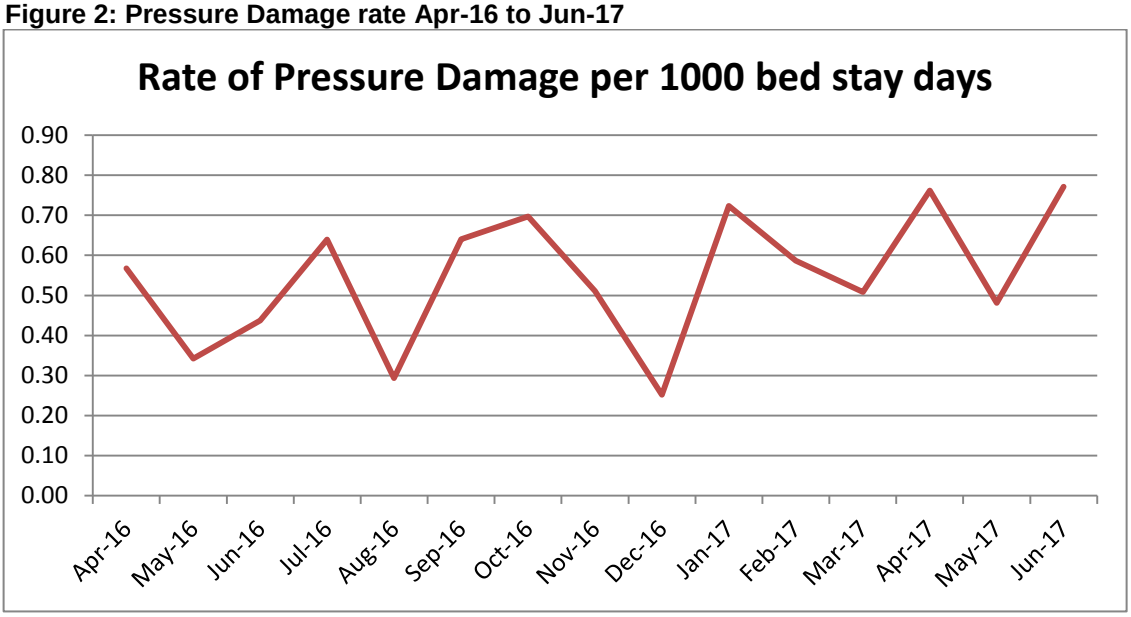

4.5 Tissue Viability

4.5.1 There were no grade 3 or 4 pressure damage between April and June.

4.5.2 Between April and June 45 incidences of grade 2 hospital acquired pressure ulcers were reported. Damage to the sacrum, buttocks and heels remains the most common form of pressure damage. Inadequate documentation of skin assessment and changes of position is a recurring theme.

4.5.3 The rate of pressure damage per 1000 bed stays days was 0.67 for the first quarter of 2017-18; this is 32% higher than the last financial year.

**Figure 2: Pressure Damage rate Apr-16 to Jun-17**




4.6 NHS Patient Safety Thermometer

4.6.1 The NHS Patient Safety Thermometer is used across all acute wards. This tool looks at point prevalence of four key harms - falls, pressure ulcers, urinary tract infections and deep vein thrombosis

(DVT) and pulmonary embolism (PE) in all patients on a specific day in the month. A dashboard is available to each ward showing Trust-wide and ward-level data for each individual harm as well as the harm-free care score. These numbers are also shared via the new ward screens.

4.6.2 The harm-free care score for the first quarter of 2017-18 in March was 96.0% against the target of 95%. The national average is 94.2%.

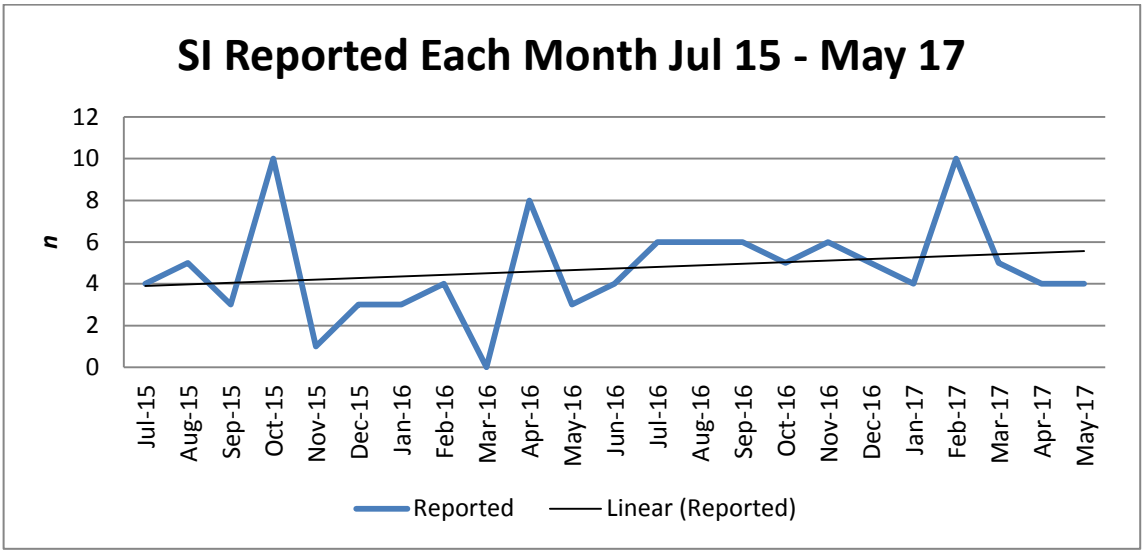
4.6.3 National data relating to the NHS safety thermometer is available below:

http://www.safetythermometer.nhs.uk/

4.7 Exception Reports Relating to Safety

4.7.1 Because of the unexpectedly high number of SI's reported in February (n=10) the Trusts two Serious Incident Investigators are currently experiencing a serious challenge in delivering SI investigations within the timescales set out in the National Serious Incident framework .

4.7.2 Over the past 24 months 109 SI investigations have been undertaken. During this period there has been a steady increase in the number of SI's declared. As the linear regression line indicates the workload has increased by 50% in the past two years from just under four SI's on average each month to just under six.




4.7.3 There are no strong emerging themes however there have been several cases relating to death or potentially avoidable harm for patients on waiting lists. It is also probably that the number of SI's will rise further with the national introduction of structured mortality reviews. This process has the potential to identify unexpected deaths where there is concern about the level of care delivered

## 5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 During this quarter 262 complaints were received, averaging 87 per month. This number is down on the average for the past 12 months which has been 112.

5.1.2 Vacancies within the Complaints team at the beginning of 2017 offered the opportunity to restructure our Patient Experience Services in a more cost effective way to improve the complainant pathway. Two vacant Band 6 Complaint Manager posts were converted into two Band 5 PALS Adviser posts. The team of five PALS Advisers will work closely with the Directorates, facilitating early contact with the clinical teams to ensure that patient concerns are resolved quickly via the informal route, allowing the team of complaint managers to focus on the more complex investigations which will, in turn, be resolved more quickly.

5.1.3 The Quality and Risk Committee received a Quarterly Complaints Report which provides an in-depth analysis of trends and lessons learned. The Trust is working on improving response times for complaints and has made significant improvements in the backlog of cases which was accrued during a period of long term sickness and vacancies within the department.

5.2 Friends and Family Test (FFT)

5.2.1 Patients who access hospital services are asked whether they would recommend the Trust to their friends or family if they needed similar treatment. Patients who access inpatient, outpatient, day-case, A&E and maternity are all offered the opportunity to respond to the question. April scores were above 95% for in-patients, maternity (ante-natal care and delivery care); and below 95% for A&E, maternity (post-natal care and post-natal community care, and out-patients.

**Table 4: Friends and Family Test April 2017**

| | **Percentage recommending BSUH in April - June** |
|---|---|
| Inpatient care | 96.2% |
| A&E | 88.6% |
| Maternity Friends and Family Recommend %: Antenatal care (36 weeks) | 100.0% |
| Maternity Friends and Family Recommend %: Delivery care | 96.8% |
| Maternity Friends and Family Recommend %: Postnatal ward | 90.4% |
| Maternity Friends and Family Recommend %: Postnatal community care | 80.0% |
| Trust Friends and Family Recommend %: Outpatient | 91.7% |

Friends and Family Test Response Rates:

5.2.2 Response rates for in-patients remains poor, at just above 10%. The Charitable Funds Committee agreed in principle funding for the service provided by Healthcare Communications (as for A&Es and maternity) but the funding source has yet to be confirmed.

5.3 Exception Reports Relating to Patient Experience

5.3.1 Response times for complaints are significantly short of the 90% target, although the backlog of complaints has reduced. The restructuring of the complaints and PALS team and recruitment to the team will enable improved performance.

5.3.2 Mixed sex accommodation breaches at 76 in April are disproportionately high, and largely arise from poor patient flow at the RSCH site.

5.3.3 Response rates for the Friends and Family Test are low and require improvement in all areas.

## 6. CARE QUALITY COMMISSION (CQC)

6.1 CQC Inspection

6.1.1 The CQC undertook inspection of the Trust on 25th to 27th April 2017. Verbal feedback was provided following the meeting and summarised in a letter received by the Trust on 28th April.

6.1.2 The CQC feedback and Trust response are discussed in a separate Board agenda item.

## 7. RECOMMENDATION

7.1 The Board is asked to note the contents of this report.